Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address
TEXAS ORTHOPEDIC HOSPITAL
c/o HOLLAWAY & GUMBERT
3701 KIRBY DRIVE, SUITE 1288
HOUSTON TX 77098-3926

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
AMERICAN HOME ASSURANCE CO

MFDR Tracking Number
M4-09-1912-01

Carrier's Austin Representative Box
19

MFDR Date Received
OCTOBER 29, 2008

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary Dated OCTOBER 27, 2008: "…In closing, it is the position of the Provider that all charges relating to the admission of this claimant are due and payable and not subject to the improper reductions take by the carrier in this case. The carrier's position is incorrect and in violation of the ACIHFG."

Amount in Dispute: $46,858.95

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary Dated NOVEMBER 14, 2008: "On basis of all available documentation, reimbursement correctly calculated per ACIHFG surgical per diem."

Response Submitted by: CLAIMS MANAGEMENT, INC P.O. BOX 1288, BENTONVILLE, AR 72712-1288

Respondent's Supplemental Position Summary Dated NOVEMBER 18, 2008: "No additional payment is recommended at this time…"

Response Submitted by: HOFFMAN KELLEY L.L.P. 400 West 15th Street, Suite 1520, Austin, TX 78701

SUMMARY OF FINDINGS

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
November 5, 2007 through November 8, 2007	Inpatient Hospital Services	$46,858.95	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 and §133.307, 31 *Texas Register* 10314, applicable to requests filed on or after January 15, 2007, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.305 and §133.307, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §134.401, 22 *Texas Register* 6264, effective August 1, 1997, sets out the fee guidelines for inpatient services rendered in an acute care hospital.

The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated JANUARY 3, 2008

- 11 THE RECOMMENDED ALLOWANCE FOR THE SUPPLY WAS BASED ON THE ATTACHED INVOICE
- 13 AN ADDITIONAL ALLOWANCE HAS BEEN RECOMMENDED FOR IMPLANTS/PROSTHETICS
- W1 WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
- 309 THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE
- 5036 COMPLEX BILL – REVIEWED BY MEDICAL COST ANALYSIS TEAM UR/JE

Explanation of benefits dated MARCH 24, 2008

- 11 THE RECOMMENDED ALLOWANCE FOR THE SUPPLY WAS BASED ON THE ATTACHED INVOICE
- 13 AN ADDITIONAL ALLOWANCE HAS BEEN RECOMMENDED FOR IMPLANTS/PROSTHETICS
- W1 WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
- 309 THE CHARGE FOR THIS PROCEDURE ESCEEDS THE FEE SCHEDULE ALLOWANCE
- 5036 COMPLEX BILL – REVIEWED BY MEDICAL COST ANALYSIS TEAM UR/UE

Explanation of Benefits dated APRIL 9, 2008

- 11 THE RECOMMENDED ALLOWANCE FOR THE SUPPLY WAS BSED ON THE ATTACHED INVOICE
- 13 AN ADDITIONAL ALLOWANCE HAS BEEN RECOMMENDED FOR IMPLANTS/PROSTHETICS
- W1 WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
- 169 REIMBURSEMENT BASED ON RATIO, PERCENTAGE OR FORMULA SET BY STATE GUIDELINES
- 5036 COMPLEX BILL – REVIEWED BY MEDICAL COST ANALYSIS TEAM-UR/JE

Issues

1. Did the audited charges exceed $40,000.00?
2. Did the admission in dispute involve unusually extensive services?
3. Did the admission in dispute involve unusually costly services?
4. Is the requestor entitled to additional reimbursement?

Findings

This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 Texas Administrative Code §134.401, titled *Acute Care Inpatient Hospital Fee Guideline*, effective August 1, 1997, 22 Texas Register 6264. The Third Court of Appeals' November 13, 2008 opinion in *Texas Mutual Insurance Company v. Vista Community Medical Center, LLP*, 275 *South Western Reporter Third* 538, 550 (Texas Appeals – Austin 2008, petition denied) addressed a challenge to the interpretation of 28 Texas Administrative Code §134.401. The Court concluded that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed $40,000 and that an admission involved unusually costly and unusually extensive services." Both the requestor and respondent in this case were notified via form letter that the mandate for the decision cited above was issued on January 19, 2011. Each was given the opportunity to supplement their original MDR submission, position or response as applicable. The documentation filed by the requestor and respondent to date will be considered in determining whether the admission in dispute is eligible for reimbursement under the stop-loss method of payment. Consistent with the Third Court of Appeals' November 13, 2008 opinion, the division will address whether the total audited charges ***in this case*** exceed $40,000; whether the admission and disputed services ***in this case*** are unusually extensive; and whether the admission and disputed services ***in this case*** are unusually costly. 28 Texas Administrative Code §134.401(c)(2)(C) states, in pertinent part, that "Independent reimbursement is allowed on a case-by-case basis if the particular case exceeds the stop-loss threshold as described in paragraph (6) of this subsection…" 28 Texas Administrative Code §134.401(c)(6) puts forth the requirements to meet the three factors that will be discussed.

1. 28 Texas Administrative Code §134.401(c)(6)(A)(i) states "…to be eligible for stop-loss payment the total audited charges for a hospital admission must exceed $40,000, the minimum stop-loss threshold." Furthermore, (A) (v) of that same section states "…Audited charges are those charges which remain after a bill review by the insurance carrier has been performed…" Review of the explanation of benefits issued by the carrier finds that the carrier did not deduct any charges in accordance with §134.401(c)(6)(A)(v); therefore the audited charges equal $76.069.49. The division concludes that the total audited charges exceed $40,000.

2. The requestor in its position statement does not address unusually extensive services. The requestor presumes that it is entitled to the stop loss method of payment because the audited charges exceed $40,000. As noted above, the Third Court of Appeals in its November 13, 2008 opinion rendered judgment to the contrary. The Court concluded that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed $40,000 and that an admission involved…unusually extensive services." The requestor failed to discuss or demonstrate that the particulars of the admission in dispute constitute unusually extensive services; therefore, the division finds that the requestor did not meet 28 TAC §134.401(c)(6).

3. In regards to whether the services were unusually costly, the requestor does not address unusually costly services. The Third Court of Appeals' November 13, 2008 opinion concluded that in order to be eligible for reimbursement under the stop-loss exception, a hospital must ***demonstrate*** that an admission involved unusually costly services thereby affirming 28 Texas Administrative Code §134.401(c)(6) which states that "Stop-loss is an independent reimbursement methodology established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker." The requestor failed to discuss the particulars of the admission in dispute that constitute unusually costly services; therefore, the division finds that the requestor failed to meet 28 TAC §134.401(c)(6).

4. For the reasons stated above the services in dispute are not eligible for the stop-loss method of reimbursement. Consequently, reimbursement shall be calculated pursuant to 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount* and §134.401(c)(4) titled *Additional Reimbursements.* The division notes that additional reimbursements under §134.401(c)(4) apply only to bills that do not reach the stop-loss threshold described in subsection (c)(6) of this section.

   - Review of the submitted documentation finds that the services provided were surgical; therefore the standard per diem amount of $1,118.00 per day applies. Division rule at 28 Texas Administrative Code §134.401(c)(3)(ii) states, in pertinent part, that "The applicable Workers' Compensation Standard Per Diem Amount (SPDA) is multiplied by the length of stay (LOS) for admission…" The length of stay was three days. The surgical per diem rate of $1,118.00 multiplied by the length of stay of three days results in an allowable amount of $3,354.00.
   - 28 Texas Administrative Code §134.401(c)(4)(C) states "Pharmaceuticals administered during the admission and greater than $250 charged per dose shall be reimbursed at cost to the hospital plus 10%. Dose is the amount of a drug or other substance to be administered at one time." A review of the submitted itemized statement finds that the requestor billed two units of Hydromorphone 20MG/100 at $454.75/unit, for a total charge of $909.50. The requestor did not submit documentation to support what the cost to the hospital was for Hydromorphone 20MG/100. For that reason, reimbursement for these items cannot be recommended.
   - The division notes that 28 Texas Administrative Code §134.401(c)(4)(A), states "When medically necessary the following services indicated by revenue codes shall be reimbursed at cost to the hospital plus 10%: (i) Implantables (revenue codes 275, 276, and 278), and (ii) Orthotics and prosthetics (revenue code 274)." Review of the requestor's medical bills finds that the following items were billed under revenue code 0278 and are therefore eligible for separate payment under §134.401(c)(4)(A) as follows:

Rev Code	Itemized Statement Description	Cost Invoice Description	UNITS / Cost Per Unit	Total Cost	Cost + 10%
278	SNI ROD THR 60 102300	THREAD ROD 60MM	4 at $8.59 ea	$34.36	$37.80
278	SNI ROD THR 250 102311	THREAD RO 250MM	4 at $16.50 ea	$66.00	$72.60

278	SNI ROD THR 300	No Invoice Provided	$0.00	$0.00	$0.00
278	SNI SUPRT MAL3H 101401	No Invoice Provided	$0.00	$0.00	$0.00
278	SNI POST FEMAL 3 H 1015	No Invoice Provided	$0.00	$0.00	$0.00
278	SNI RNG FUL 180 710701	FULL RING 180MM	5 at $504.73 ea	$2,523.65	$2,776.02
278	SNI RNG ½ 180 710701	HALF RING 180 MM	1 at $458.54 ea	$458.54	$504.39
278	SNI RNG FT 180L 710701	FOOT RING 180 MM LONG	1 at $550.08 ea	$550.08	$605.09
278	SYSCREW3.5X18LCK 212105	3.5MM LOCKING SCREW SLF-TPNG W/STARDRIVE ™ RECESS 18MM	4 at $103.55 ea	$414.20	$455.62
278	SYSCREW3.5X22LCK 212107	3.5MM LOCKING SCREW SLF-TPNG W/ STARDRIVE (TM) RECESS 22MM	1 at $103.55 ea	$103.55	$113.91
278	SYSCREW3.5X24LCK 212108	3.5MM LOCKING SCREW SLF-TPNG W/STARDRIVE (TM) RECESS 24MM	1 at $103.55 ea	$103.55	$113.91
278	SCR SYN 204018 CORT 3	3.5MM CORTEX SCREW SELF TAPPING 30MM	1 at $19.95 ea	$19.95	$21.95
278	SNI FIX BOLT CANN 1006	NO INVOICE PROVIDED	$0.00	$0.00	$0.00
278	SNI FIX BOLT SLOT 1007	NO INVOICE PROVIDED	$.00	$0.00	$0.00
278	SSNI BOLT 16MM 103201	BOLT 16MM	22 at $1.45	$31.90	$35.09
278	SNI NUT 10MM 103300	NUT 10MM	78 billed only 50 supported at $1.45 ea	$72.50	$79.75
278	SNI NUT 4 PT D/C 10330	DC COUNTER 4 POINT	7 billed only 4 supported at $32.02 ea	$128.08	$140.89
278	SNI SOCKET THR 20 1009	THD SOCKET 20 MM LENGTH	4 at $15.55 ea	$62.20	$68.42
278	SNI BUSHING 100800	NO INVOICE PROVIDED	$0.00	$0.00	$0.00
278	SNI WIRE 1.8X370 10210	NO INVOICE PROVIDED	$0.00	$0.00	$0.00
278	SNIE WIRE OLV 1.8 10210	NO INVOICE PROVIDED	$0.00	$0.00	$0.00
278	SCR SY 204216-38 PT 3	NO INVOICE PROVIDED	$0.00	$0.00	$0.00
278	PLT SY 223561 3.5 6H L	NO INVOICE PROVIDED	$0.00	$0.00	$0.00

TOTAL ALLOWABLE	$5,025.42

The division concludes that the total allowable for this admission is $3,354.00 + 5,025.42. The respondent issued payment in the amount of $10,193.17. Based upon the documentation submitted, no additional reimbursement can be recommended.

Conclusion

The submitted documentation does not support the reimbursement amount sought by the requestor. The requestor in this case demonstrated that the audited charges exceed $40,000, but failed to demonstrate that the disputed inpatient hospital admission involved unusually extensive services, and failed to demonstrate that the services in dispute were unusually costly. Consequently, 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount,* and §134.401(c)(4) titled *Additional Reimbursements* are applied and result in no additional reimbursement.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	11/29/12 Date

Signature	Medical Fee Dispute Resolution	11/29/12 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.